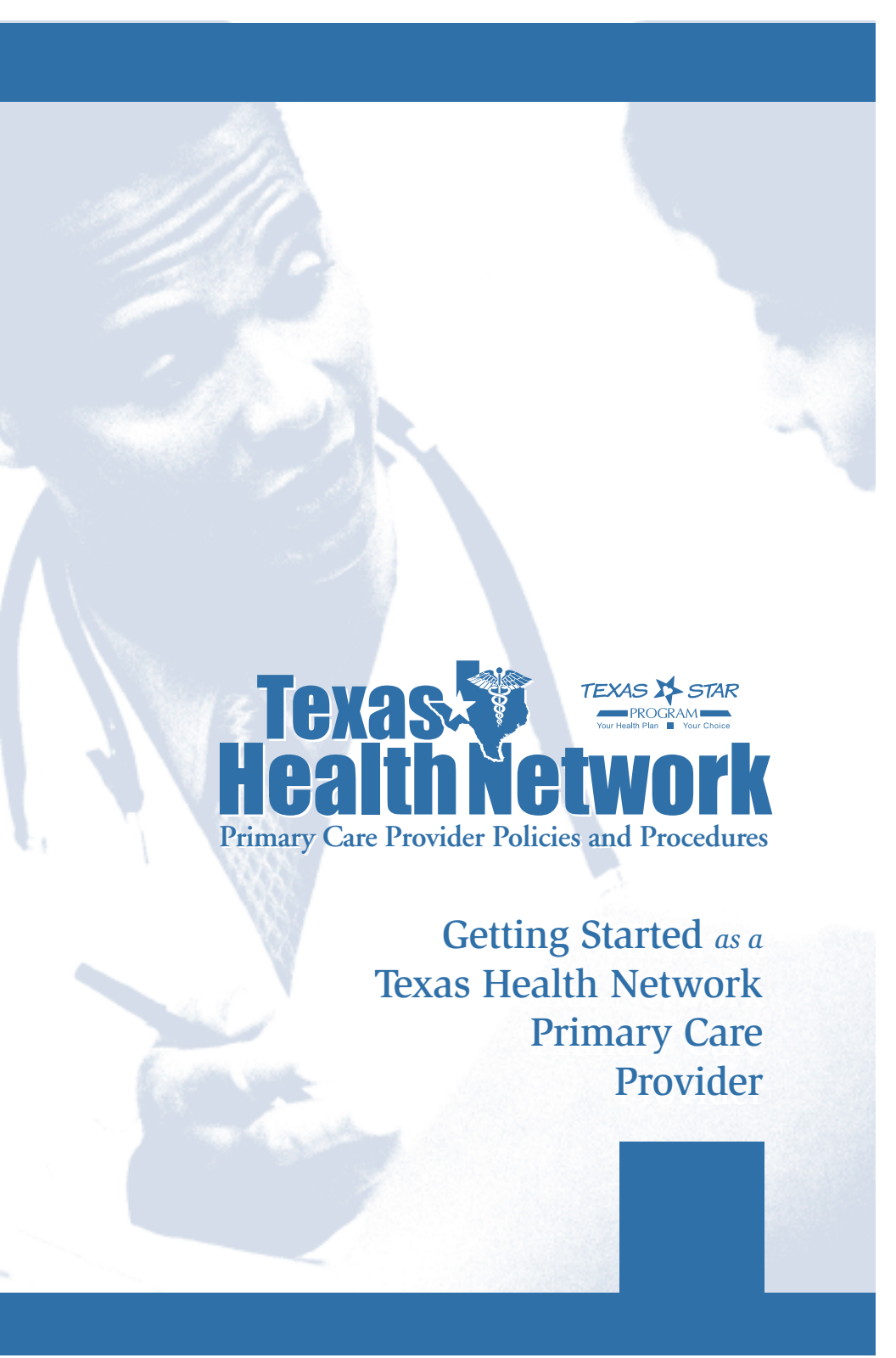

Texas Health Network

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

Primary Care Provider Policies and Procedures

Getting Started *as a* Texas Health Network Primary Care Provider

Texas Health Network
Quick Reference

Texas Health Network Provider Helpline
24 hours a day, 7 days a week
1-888-834-7226
Fax: 1-512-302-5068

Texas Health Network Utilization Management Helpline
(Precertification, etc.)
24 hours a day, 7 days a week
1-888-302-6167
Fax: 1-512-302-5039

FirstHelp™ Clinical Helpline
24 hours a day, 7 days a week
1-800-304-5468

Texas Health Network Member Helpline
24 hours a day, 7 days a week
1-888-302-6688

Automated Inquiry System (AIS)
24 hours a day, 7 days a week
1-800-925-9126
or (512) 345-5948 or (512) 345-5949
See the AIS User's Guide in the *Texas Medicaid Provider Procedures Manual*

contents

INTRODUCTION

Thank you for your participation in the Texas Health Network. Your participation is appreciated and is essential to the success of Medicaid in Texas. This manual should answer most of the questions you have about the Texas Health Network, its policies, and procedures. If you don't find what you're looking for in the pages that follow, give us a call at one of the numbers listed on the inside cover of this manual.

Texas STAR Program Background

The Texas STAR (State of Texas Access Reform) Program was established in 1993 when the Texas Legislature adopted legislation which authorized the Texas Health and Human Services Commission to undertake a comprehensive restructuring of the Texas Medicaid Program. This restructuring introduced to the Texas Medicaid Program a new delivery system known as the Primary Care Case Management (PCCM) managed care health delivery system.

Through the development and implementation of the Texas Health Network, the State intends to achieve the following goals:

- Enhance access to care
- Promote quality and continuity of care
- Ensure appropriate utilization of services
- Improve cost effectiveness
- Improve provider and member satisfaction

Texas Health Network Background

The Texas Health Network is the State's Primary Care Case Management (PCCM) plan. PCCM, operating in Texas under the name "Texas Health Network," is a managed fee-for-service system emphasizing primary and preventive care for Medicaid clients (this includes families, pregnant women, and children). It is not an HMO, and involves no capitated payment to providers. The Texas Health Network is administered on the State's behalf by Birch & Davis Health Management Corporation (BDHMC). BDHMC develops and contracts on behalf of the State with a network of PCPs who are responsible for managing and coordinating Medicaid patients' care.

The network is open to any PCP who meets the State's credentialing requirements. The following provider types may participate as a PCP:

- Pediatricians
- Family/General Practitioners
- Internists
- OB/GYNs
- Advance Nurse Practitioners (family practice, women's health, or pediatrics)
- Certified Nurse Midwives
- Rural Health Clinics
- FQHCs
- Specialists willing to provide medical homes to select members with special needs

PCPs receive Medicaid fee-for-service payments based on the Texas Medicaid Reimbursement Methodology (TMRM) structure—plus a $3.00 per-member-per-month case management fee. This case management fee is compensation for managing the medical care of Texas Health Network members who have either selected or who have been assigned to your practice.

The Texas Health Network will not alter PCPs' existing referral relationships to Medicaid specialists or facilities.

PROVIDER RESPONSIBILITIES

Medical Home

As a PCP, you provide a medical home for a group of Texas Health Network members, and manage all primary care services for these members. This includes preventive services, such as immunizations, well child care, episodic illness care, and coordinating Texas Health Steps exams if you do not provide them. Texas Health Steps (THSteps) is the State's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. For information on THSteps, see the current *Texas Medicaid Provider Procedures Manual*.

PCPs may contract to treat only current or established patients. PCPs may indicate that new patients are also accepted.

Responsibilities of PCPs in the Texas Health Network are very similar to services PCPs provide today. Specific requirements include:

- Either furnish or arrange patient care on a 24-hour, 7-day basis (acceptable arrangements are listed on page 5).
- Refer members to an approved Texas Medicaid provider or facility that accepts Texas Health Network members when the needed services are not available through your office or clinic.
- Coordinate, monitor, and document medical treatment and covered services delivered by all providers to each member, including treatment during inpatient stays.
- Verify the eligibility of each member prior to providing covered services to determine whether the member is eligible for services under the Texas Health Network on the date of service.
- Coordinate care for children receiving services from or who have been placed in the conservatorship of the Texas Department of Protective and Regulatory Services (TDPRS). PCPs are responsible for furnishing or arranging for all medically necessary services while the child is under the conservatorship of TDPRS and until the child is placed in foster care and is no longer eligible for Texas STAR Program enrollment.

PCPs should also be actively involved in educating their patients regarding appropriate use of the emergency room and other services.

Preventive services are to be provided using clinically accepted guidelines and standards, including those of the American Academy of Pediatrics, the United States Public Health Service, the American Academy of Family Physicians, and the American College of Obstetrics and Gynecology.

Provider Availability

PCPs are expected to provide 24-hour, 7-day a week telephone access to needed medical care for members, either directly or through on-call arrangements. Continuous coverage can be provided through direct access to your office and/or through on-call arrangements with another office or service. Members should be informed of your normal office hours and should be

instructed how to access urgent medical care after normal office hours. You are required to have at least one of the following arrangements in place to provide 24-hour, 7-day a week coverage for Texas Health Network members:

- Have your office phone answered after hours by a medical exchange or a professional answering service. If an answering service is used, the following must be met:
  - The answering exchange or service must be able to contact you or a designated back-up provider for immediate assistance.
  - The PCP, or designated back-up provider, must be notified of all calls.
  - All calls must be returned in a timely manner by the PCP or designated back-up. The Texas Health Network strongly recommends member calls be returned within 30 minutes.
  - The answering service must meet the language requirements of the major Medicaid population groups (English and Spanish).

- Have your office phone answered after office hours by an answering machine that instructs the member (in the language of the major Medicaid population groups) to do one of the following:
  - Call the name and phone number of a medical facility (e.g., after hours clinics, emergency departments, etc.) where the member can request to speak with a medical professional to determine whether emergency treatment is appropriate.
  - Call another number where you can be reached.
  - Call the name and phone number of a medical professional serving as your designated back-up. In this situation, the member must be able to speak with the back-up provider or a clinician who can offer immediate assistance.

- Have your office phone transferred after hours to another location where someone will answer and be able to contact you or your designated back-up provider.

Unacceptable Telephone Arrangements are:

- An office phone that is answered only during office hours
- An office phone answered after hours by an answering machine recording that tells members to leave a message
- An office phone answering machine recording that informs members of regular office hours and requests that they call back during those hours
- An office phone that is answered by a recording or an answering service that directs members to go to the emergency room

PCPs in certain areas of the state may not currently provide coverage as detailed above. If you would like clarification regarding availability requirements (24-hour, 7-day a week) call the Texas Health Network Provider Helpline at 1-888-834-7226. A Provider Relations professional will assist you in finding a solution that works best for your practice.

Referrals

The Texas Health Network has an open specialty referral network. You may refer your members to any Texas Medicaid-enrolled provider for diagnosis and/or treatment of covered services you do not provide. PCP-to-PCP referrals are managed in the same way as PCP-to-Specialist referrals. You must give the PCP or specialist your Texas Provider Identifier (TPI) number at the time of referral. This number acts as your authorization for the member to be seen by that provider. The PCP or specialist must enter this number in the appropriate field on the claim(s) submitted for the approved visit(s). You may authorize one visit, a specified number of visits, or a specified period of time. This process is part of your responsibility to manage the care of your members.

If a specialist (or referred-to PCP) needs to refer the member to another specialist(s), the need for the referral must be communicated back to the PCP with recommendations. The PCP then authorizes the referral to the second specialist, following the same procedure described above.

The provider is encouraged to use a referral form to help the Texas Health Network identify members with chronic, complex health needs so the member can be offered additional support and coordination services. Any form can be used and faxed to the Texas Health Network Utilization

Management Department at 1-512-302-5039. The Texas Health Network Referral Form is located in the center of this manual for your convenience.

Credentialing

PCPs contract directly with the State of Texas as Medicaid and Texas Health Network providers. Any Medicaid-enrolled provider of the type eligible to participate as a PCP, must review the contract addendum, and complete and return the attestation form. Upon receipt of the attestation form, providers enter a provisional credentialing period. This period lasts for 12 months. Providers are required to comply with the credentialing process.

PCPs must meet all credentialing requirements, including:

- **Ability to Perform or Directly Supervise the Ambulatory Primary Care Services of Members**—Provider performance is monitored on an ongoing basis by the Texas Health Network.

- **Admitting Privileges**—The PCP must maintain admitting privileges with a Texas Health Network-contracted hospital, or make arrangements with another Texas licensed physician who is an eligible Medicaid provider and who maintains admitting privileges with a contracted Texas Health Network hospital.

- **Education Sessions**—The Texas Health Network disseminates Utilization Management (UM), Continuous Quality Improvement (CQI), and case management policies and procedures to each Texas Health Network PCP. The Texas Health Network also provides a series of educational sessions regarding all aspects of UM, CQI and case management. PCPs are encouraged to attend at least one educational session on UM, CQI, and case management policies and procedures each year.

- **Liability Coverage**—Obtain and maintain an acceptable general liability insurance policy as well as a professional liability insurance policy in an appropriate amount. At a minimum, the limits of liability are $100,000 per occurrence and $300,000 in the aggregate.

SERVICES TO BE PROVIDED

Covered Services

Texas Health Network members are entitled to all medically necessary services currently covered under the Texas Medicaid Program. In addition, Texas Health Network members receive:

- **Unlimited Medically Necessary Inpatient Days**—The 30-day inpatient "spell of illness" limitation has been removed for Texas Health Network members age 21 and over. Members under the age of 21 have this benefit through the Comprehensive Care Program (CCP) of Texas Health Steps.

- **Annual Adult Physical Exams**—Annual physical exams performed by the PCP are a covered benefit for members age 21 and older. The annual physical exam is available in addition to family planning services.

Freedom-of-Choice Services

Members may self-refer for emergency care, family planning services, THSteps, vision services, behavioral health services, certain case management services, and certain school health services. These are considered Freedom-of-Choice services. Each member is encouraged to communicate self-referred services back to his or her PCP. As a PCP, you may be called by emergency room staff to authorize non-emergent services for your member in the ER, as you would for any other provider (see Referrals, page 6). In this situation, your timely response is required.

Behavioral Health Services

Behavioral health services are provided for the treatment of mental disorders, emotional disorders, and chemical dependency disorders. Though a referral is not required for a member to seek behavioral health services, a PCP may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. There are also other services provided through the Texas Department of Mental Health and Mental Retardation (TDMHMR) such as case management for mental health and mental retardation, mental health rehabilitation services, and mental retardation diagnosis and assessment services.

Texas Health Network members may receive any behavioral health service that is medically necessary, currently covered by the Texas Medicaid Program, and provided by a Medicaid-enrolled behavioral health provider.

To ensure continuity of care, behavioral health providers are encouraged to contact a member's PCP to discuss the patient's general health. PCPs are encouraged to maintain contact with the behavioral health provider to document behavioral health assessments and treatments, and to inform the behavioral health provider of the member's health status that may impact the behavioral health service delivery.

Refer to the current *Texas Medicaid Provider Procedures Manual* for information on confidentiality and release of patient information.

The Texas STAR Program annually conducts focus studies for the purpose of improving the detection and treatment of specific disorders (i.e., depression) by PCPs providing behavioral health services to Texas Health Network members.

OB/GYN Services

Texas Health Network members may select a Texas Health Network-contracted OB/GYN as their PCP. As a PCP, the OB/GYN is responsible for providing or arranging for all medically necessary services. OB/GYNs may choose to act as the PCP only during the member's pregnancy, or postpartum as well. Texas Health Network members may also seek direct services of any Medicaid enrolled OB/GYN who is not their PCP for the following services:

- One well-woman examination per year
- Care related to pregnancy
- Care for all active gynecological conditions and
- Diagnosis, treatment, and referral to a Medicaid-enrolled specialist within the network for any disease or condition within the scope of the designated professional practice of a licensed obstetrician or gynecologist, including treatment of medical conditions concerning the breasts.

Routine, Urgent, And Emergency Services

Definitions

Routine A symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical and/or diagnostic studies prior to diagnosis and treatment.

Urgent A symptom or condition that is not an emergency, but requires further diagnostic work-up and/or treatment within 24 hours to avoid a subsequent emergent situation.

Emergent A medical condition, including behavioral health, that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the failure to treat immediately to result in one or all of the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily function;
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman having contractions:
  - — That there is inadequate time to effect a safe transfer to another hospital before delivery, or
  - — That transfer may pose a threat to the safety of the woman or the unborn child
- With respect to a behavioral health condition, a person having symptoms may:
  - — present a danger to themselves or others, or
  - — render the member incapable of controlling, knowing, or understanding the consequences of his or her actions.

Service Standards

Appointments must be made available for medically necessary services within the following guidelines:

- Urgent Care: within 24 hours after the request
- Routine Care: within two weeks after the request
- Physical/Wellness Exams: within four to eight weeks after the request
- Prenatal Care: initial visit within 14 calendar days of the request or by the 12th week of gestation

Member eligibility must be verified prior to providing covered services to determine whether the member is eligible for services under the Texas Health Network on the date of service. For more information on verifying eligibility, see page 13 of this manual.

PRECERTIFICATION

Procedures Requiring Precertification

Precertification is the process by which the Texas Health Network determines if a procedure or admission meets evidence-based criteria for medical necessity. The list of services requiring precertification is minimal, consisting mainly of high cost or unusual services. Precertification is required for the procedures listed below:

- Certain office or outpatient procedures including MRIs, MRAs, all laser surgeries, endoscopic procedures, all podiatry procedures, pH probe tests, and sleep studies
- Specialist-to-specialist referrals (unless authorized by the PCP)
- All non-emergent surgical procedures, including those performed during authorized hospital admissions
- All non-emergent inpatient admissions (excluding routine deliveries/newborns)

If you need to obtain precertification, you may call the Texas Health Network Utilization Management Department at 1-888-302-6167. You may also request a precertification by fax at 1-512-302-5039.

The Texas Health Network has developed a precertification form to assist you in submitting the information necessary to approve the request. This form is located in the center of this manual.

Although your request for an inpatient admission, outpatient or inpatient procedure is processed within 24-48 hours or the next business day, please allow 4 business days to process your request. Urgent requests are given priority and are reviewed and processed within 1 business day. Each request is reviewed, using evidence-based criteria, for medical necessity and appropriate level of care. Only Registered Nurses and Licensed Vocational Nurses trained in utilization and concurrent review assess the request. Any request not meeting criteria is forwarded to a Texas Health Network Medical Director for review and disposition.

Once criteria have been met and the precertification is approved, the precertification number is called or faxed back to your office. In the event a request cannot be approved with the information provided, you may be asked to submit additional information. In this case, providers are always notified by the next business day if a request does not meet criteria.

You must contact the Texas Health Network for some procedures performed on an emergent basis in order for the claim to be adjudicated (e.g., emergency surgical procedures).

The precertification number must be entered in the appropriate field when submitting a HCFA 1500. If a service is denied, a letter indicating the reason(s) for denial will be mailed to your office, and to the member.

COMPLAINTS AND APPEALS

Provider satisfaction is one of the goals of the Texas STAR Program and a top priority of the Texas Health Network. Let us know how we can improve our services, or if you are dissatisfied, by calling the Texas Health Network Provider Helpline at 1-888-834-7226, or sending your written complaint to the address below.

Providers have the right to appeal utilization review decisions reached by the Texas Health Network using evidence-based criteria. To appeal a decision made by the Texas Health Network, send a written request stating the reason the decision by the Texas Health Network is in question, a copy of the denial letter you received, an explanation of the appeal, and clinical documentation to support approval of the service(s). The appeal must be received by the Texas Health Network within 180 days of the determination. Appeals may be mailed to the Texas Health Network Complaint and Appeals Resolution Unit at the following address:

Texas Health Network
ATTN: Complaint and Appeals Resolution Unit
P.O. Box 14685
Austin, TX 78761
or faxed to 1-888-235-8399

If a provider is dissatisfied with the Texas Health Network's final determination, he or she may file a complaint with HHSC. Complaints must be in writing and include copies of all documentation from the provider to the Texas Health Network, and from the Texas Health Network to the provider. The final decision letter should be included as part of the documentation.

Complaints must be received at HHSC within 60 calendar days from the date of the Texas Health Network's final decision letter. Provider complaints may be mailed to the following address:

Texas Health and Human Services Commission
c/o Texas Department of Health
Provider Appeals Unit, Y-929
Provider Complaints
1100 West 49th Street
Austin, TX 78756-3172

IDENTIFYING MEMBERS

Eligibility

The Texas Department of Human Services is responsible for determining a client's Medicaid eligibility. Clients who receive certain categories of medical assistance are required to enroll in the Texas Health Network in Spring 2002. These categories include families, pregnant women, and children (TANF, or TANF-related). Additional clients in other program categories such as SSI may be enrolled in Summer 2002. Texas Health Network

members who lose Medicaid eligibility will automatically rejoin the Texas Health Network if eligibility is reestablished within 6 months.

Additional information on these categories can be found in the current *Texas Medicaid Provider Procedures Manual*.

Member Identification

Texas Health Network members will continue to receive a Medicaid ID Form 3087. This form will identify them as Texas Health Network members, and will display the name of the member's PCP. You can check eligibility for services as you always have, through the NHIC Automated Inquiry System (AIS), by using the Medicaid ID Form 3087, accessing TDHConnect, or by calling the Texas Health Network (see the inside front cover of this manual for helpful telephone numbers). You also now have the Texas Health Network monthly panel report with your list of members to verify eligibility.

Newborns

Newborns are eligible for Texas Health Network benefits from the date of birth if the baby is born to a mother who is a member of the Texas Health Network. The baby will be a member of the Texas Health Network and assigned a temporary PCP number, PCCNEWB01 until a PCP is chosen. Claims for services rendered to newborns should be filed to NHIC with PCCNEWB01 as the referring provider number until a PCP is chosen.

Member Responsibilities

Members of the Texas Health Network have defined rights and responsibilities. The Texas Health Network and PCPs share the responsibility to ensure and protect member rights and to assist members to understand and fulfill their responsibilities as plan members. These include the responsibility to:

- Seek medical care first from his or her PCP, except for emergencies and other self-referred services.
- Provide an accurate and complete personal medical history.
- Identify himself or herself as a member of the Texas Health Network when requesting medical services.
- Call the PCP for an appointment before arriving at the office to receive care.

- Call and notify the PCP as soon as possible if he or she will be late for an appointment, or if an appointment must be rescheduled.

- Pay for any non-covered service if he or she has been notified in advance that the service is not a covered benefit and he or she has signed an acknowledgment form.

Additional rights and responsibilities are detailed in the current *Texas Medicaid Provider Procedures Manual.*

Panel Reports

The Texas Health Network sends the PCP a panel report at the beginning of every month that lists the members who have either selected or who have been assigned to his or her practice. You determine the number of Texas Health Network members who choose or are assigned to your panel. It is not limited by the Texas Health Network.

Each member listed is eligible for services throughout the entire month (see *Member Identification*, page 14). PCPs are expected to render services to all members listed on their panel when services are requested. Exceptions may be made if you have been assigned a member who is outside your scope of practice, for example, outside the age range of pediatric patients you serve.

PCP Changes

A member may request a change of PCP from the Texas Health Network without cause up to four times in any enrollment year. In addition, a member may request a change for any of these reasons:

- The member is dissatisfied with the care or treatment they have received.

- The member's condition or illness would be better treated by another provider type.

- The member's new address is no longer convenient to the PCP's location.

- The provider leaves the program (e.g. moves, no longer accepts Medicaid, or is removed from Medicaid enrollment).

- The member/PCP relationship is not mutually agreeable.

A member may be reassigned to another PCP for the following reasons. Please notify the Texas Health Network if any of these situations occur:

- The member is not included in PCP's scope of practice.
- The PCP requests that the member be reassigned due to noncompliance with medical advice or unacceptable office decorum.
- The member/PCP relationship is not mutually agreeable.

A member may also be reassigned if:

- The PCP is no longer a Texas Health Network provider.
- The PCP exhibits a documented pattern of unacceptable quality of care.
- The PCP is sanctioned by the Texas Health Network.
- The PCP inappropriately limits the member's access to covered specialty services.

CULTURAL COMPETENCY AND SENSITIVITY

The Texas Health Network values the diversity of the Texas Medicaid population and has programs to support multicultural plan membership. All Texas Health Network materials are written at a 4th to 6th grade reading level, and printed in both English and Spanish. Provider newsletters and educational workshops include topics that focus on cultural sensitivity and the need for culturally competent staff in PCP offices. Providers are expected to comply with the laws concerning discrimination on the basis of race, color, national origin, or sex. These laws include Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and the Rehabilitation Act of 1973.

Title VI, section 601, of the Civil Rights Act of 1964 states that "no person in the United States shall on the basis of race, color, or national origin, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." The U.S. Department of Health and Human Services, Office of Civil Rights (OCR) issued in August of 2000 a policy guidance on the "Prohibition against National Origin Discrimination as it Affects Persons with Limited English Proficiency." This guidance on Title VI of the Civil

Rights Act clarifies that health and social service providers must take adequate steps to ensure that persons with limited English proficiency receive language assistance necessary to afford them meaningful access to programs and services, free of charge. Additional information, including the complete OCR guidance on persons with limited English proficiency, may be found on the Internet at www.hhs.gov/ocr/lep

In addition, providers are required to adhere to the Americans with Disabilities Act of 1990. The U.S. Department of Justice provides information about the Americans with Disabilities Act (ADA) through a toll-free ADA Information Line at 1-800-514-0301, or go to http://www.usdoj.gov/crt/ada/adahom1.htm

Interpreter/Linguistic Services

It is the provider's responsibility to ensure that interpreter services, including American Sign Language, are available at no cost to his/her members. When interpreter services are necessary to ensure effective communications regarding diagnosis, treatment plan, medical history, or health education, you may contact the Texas Health Network Member Helpline at 1-888-302-6688. If your staff is in need of interpreter services to meet the OCR requirement on Limited English Proficiency, you may also contact AT&T at 1-800-752-0093. For assistance to members who are hearing impaired, call Relay Texas at 1-800-735-2989 (TDD), or 1-800-735-2988 (Voice).

TEXAS HEALTH NETWORK SUPPORT SERVICES

FirstHelp™

FirstHelp™ is a toll-free 24-hour clinical helpline for Texas Health Network members. Using clinical algorithms approved by State medical directors, registered nurses answer members' questions about self care for common conditions, provide education on health-related topics, and recommend when they should see their PCP or go to the emergency room.

Provider and Member Helplines

In addition to FirstHelp™, the Texas Health Network operates a Provider Helpline and a Member Helpline. Both are toll-free, and staffed by knowledgeable customer service agents who provide information about the program, its policies, and benefits.

Member Handbook
Texas Health Network members are given an informative Member Handbook detailing their rights and responsibilities as members of the Texas Health Network.

Provider Education
In addition to this manual, PCPs receive, on a quarterly basis, the Texas Health Network newsletter, the *Network Reporter*. Policy and procedural changes are communicated regularly through the *Network Reporter,* the NHIC *Medicaid Bulletin*, and included with the monthly panel report.

CLAIMS

Claims Processing

All claims for services provided to Texas Health Network members should be filed to the Claims Administrator, NHIC, in accordance with the procedures specified in the current *Texas Medicaid Provider Procedures Manual*. All Medicaid claims filing rules apply.

PCPs receive Medicaid fee-for-service payment for care they provide to Texas Health Network members, in addition to a case management fee. The case management fee is $3.00 per member per month and is paid to the PCP in a separate check no later than the tenth State working day of each month. Checks are issued by the claims administrator, NHIC.

Billing Members

Before rendering services, providers should always inform members that the cost of services not covered by the Texas Medicaid Program can be charged to the member.

A provider may only bill a Texas Health Network member for a service that is not medically necessary or not a covered benefit if both of the following conditions are met:

- The patient requests a specific service or item that in the opinion of the provider may not be reasonable and medically necessary.
- The provider obtains and keeps a written acknowledgment statement verifying that the provider has notified the member of financial responsibility for services rendered. This acknowledgment must be signed by the member. If the service the member requested is determined not to be medically necessary by the

Texas Health Network, or NHIC, the signed acknowledgment statement must indicate that the member has been notified of the responsibility of paying the bill. A sample Acknowledgement Statement can be found in the current *Texas Medicaid Provider Procedures Manual*.

There is no co-payment for Texas Health Network members.

FRAUD AND ABUSE POLICY

Federal and State law give authority to the Texas Health and Human Services Commission (HHSC) to identify, investigate and refer cases of suspected fraud and/or abuse in the Medicaid or social services program. HHSC takes appropriate action to protect clients and the Medicaid program when providers of services are suspected of fraudulent or abusive activities. HHSC may impose sanctions against a provider or a provider's employee who permits, causes, or commits any fraud or abuse defined by law. Individuals having knowledge of suspected Medicaid fraud or abuse should report this information to the Medicaid Fraud Hotline at 1-888-752-4888.

MORE INFORMATION

For questions, or for more information on any of the topics covered in this manual, please contact the Texas Health Network Provider Helpline at 1-888-834-7226. Additional telephone numbers are printed on the inside front cover of this manual. Information on specific topics can be found in the current *Texas Medicaid Provider Procedures Manual*:

Emergency Transportation Services

Texas Health Steps

TexMedNet and TDHConnect

Medical Transportation Program

P.O. Box 14685, Austin, TX 78761